# CONSENT TO SURGERY, ANESTHESIA, MEDICAL TREATMENT OR OTHER PROCEDURE

Oregon State law guarantees that you have both the *right* and the *obligation* to make decisions concerning your healthcare. Your doctor must provide you with the necessary information and advice, but ***you decide***.

1. I hereby give permission for Dr. _____and/or his/her associates or assistants to perform the following treatment(s) or procedure(s), which has/have been explained to me. This consent is for:
   ☐ one procedure ☐ a series of procedures:_____
   _____
   _____
2. I understand that in addition to the physician listed above, the following practitioners may perform important aspects of the treatment or procedure, specific surgical tasks, and provide anesthesia:
   _____
3. I consent to any other treatment(s)/procedure(s) and/or consultation(s) my physician determines are necessary when it is not feasible to obtain my consent.
4. I have been informed that there are anticipated benefits, but also significant risks which may go along with the performance of this or any procedure or anesthesia, that can lead to permanent or partial disability or death; including, but not limited to, severe blood loss, injury to adjacent structures, infection, and/or cardiac arrest. I have also been informed there are alternatives to this treatment, including no treatment. I agree that no warranty or guarantee has been made to me as to result or cure.
5. I consent to the hospital or doctor disposing of any tissue or parts removed from me according to usual practice.
6. To the extent it is considered advisable for my care, I consent to anesthesia, sedation, pathology laboratory services, imaging services, and medications, as authorized by my physician.
7. **(Initial)** ____ I consent to have medical equipment consultants.
8. **(Initial)** ____ I consent to medical students, physicians in training, nursing students and/or other allied health professionals observing or participating in my surgery/procedure if my physician deems it appropriate.
9. I consent to the transfusion of blood & blood products:
   **(Initial)** ____ My own blood as previously arranged
   **(Initial)** ____ From the Blood Bank as deemed medically necessary
10. **(Initial)** ____ ***I refuse blood or blood products.*** I understand that this refusal may lead to significant harm or possibly *death* in the event of a severe blood loss.
11. **(Initial)** ____ I have discussed any changes I would like to make to my advance directive/resuscitation status for this procedure with my physician and my physician has noted my decisions in the grey box below ***or*** **(Initial)** ____ **I have no advance directive or POLST (physician orders for life-sustaining treatment).**
12. **(Initial)** ____ Other: _____

My physician has asked if I want a more detailed explanation. I am satisfied with the explanation and all my questions have been answered. I give my permission and consent to the treatment(s) or procedure(s).

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient | Signature of Legal Representative and Printed Name | Date and Time |
| _____ | _____ | _____ |
| Signature of Witness* | Witness Name Printed | Date and Time |

**Witness signature is documenting that the above patient and or legal representative was the individual who signed this document.*

**Doctor Statement for PARQ & DNR Status -**

I have explained the treatment(s) or procedure(s), including the possible common risks, complications, alternative treatments (including non-treatment), and anticipated results to the patient or his/her representatives before the patient or his/her representative consented. All questions have been answered.

I have discussed the suspension of the DNR status with the patient during this procedure. DNR will be suspended for the following length of time:

☐ Through the perioperative phase (O.R. through PACU)
☐ Through the perioperative phase + _____ days
☐ Do NOT SUSPEND DNR status
☐ N/A - patient has no Advanced Directive or POLST

_____ Date: _____ Time: _____
Physician Signature

PATIENT LABEL